State of Utah
INSURANCE DEPARTMENT

Michael O. Leavitt
Governor
Merwin U. Stewart
Commissioner

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November 13, 2000

Rolando I, Galano, PhD., President and CEO
Educators Mutual Insurance Association of Utah
852 East Arrowhead Lane
Murray, Utah 84107-5298

Dear Mr. Galano:

Attached is a copy of the Market Conduct Examination Report of Educators Mutual Insurance Association of Utah, as of December 31, 1999.

Utah Code Annotated (U.C.A.) § 31A-2-204(7), provides that the examined insurer may either accept the report as written or request agency action. If a written request for agency action is not filed within twenty (20) days, from the date of this letter, the report will be officially filed as a public document.

The report described certain aspects of your operations that appear to be in violation of pertinent sections of the Utah Insurance Code. These items are being considered by our health division for appropriate administrative action. We will contact you in the near future regarding proposed remedies.

Please also be advised that, U.C.A. § 31A-2-204(8) requires that: "The examinee shall promptly furnish copies of the adopted report to each member of its board." In addition, pursuant to U.C.A. § 31A-2-205(4), "The examined insurer shall certify the consolidated account of all charges and expenses for the examination. One copy shall be retained by the insurer and the other shall be filed with the department as a public record."

If you have any questions, please feel free to contact me.

Sincerely,

MERWIN U. STEWART
Insurance Commissioner

Suzette Green-Wright, FLMI, AIE, AIRC
Director, Health Insurance Division

Enclosure
cc: Company File
Correspondence File

STATE OF UTAH INSURANCE DEPARTMENT

REPORT OF MARKET CONDUCT EXAMINATION

Of

EDUCATORS MUTUAL INSURANCE ASSOCIATION

OF UTAH

852 East Arrowhead lane

Murray Utah 84107

NAIC Company Code Number: 81701

And its subsidiaries

Educators HealthCare, an HMO

NAIC Company Code Number: 95515

And

Educators Insurance Company

NAIC Company Code Numbers: 77020, 17060

As of

December 31, 1999

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November 13, 2000

The Honorable Merwin U. Stewart
Insurance Commissioner
State of Utah Insurance Department
State Office Building, Room 3110
Salt Lake City, Utah 84114

In accordance with your instructions, an examination has been made of the market conduct practices of

Educators Mutual Insurance Association

Murray, Utah

a domestic non-profit mutual benefit association referred to in the commentary of this report as "**EMIA**." Commentary in this report covers the period January 1, 1998 through December 31, 1999, unless indicated otherwise. The examination also included its subsidiaries, Educators Insurance Company, a domestic for profit insurance company, referred to as **EIC** and Educators Health Care, a state charted non-profit health maintenance organization referred to as **EHC**. Collectively, the three companies examined are referred to as Companies. The report of such examination is herein respectfully submitted.

FOREWORD

A market conduct examination report is, in general, a report by exception. Reference to the Companies' practices, procedures, or files subject to review may be omitted if the examiner encountered no improprieties.

SCOPE OF EXAMINATION

An examiner representing the Utah Insurance Department conducted this examination. The purpose of the examination was to determine if the Companies' operations were consistent with public interest and in compliance with:

- Utah Code Annotated (U.C.A.) Title 31A and other related statutes
- Rules promulgated by the Utah Insurance Department as contained in the Utah Administrative Code (U.A.C.) applicable to U.C.A. Title 31A
- Standards contained in the Market Conduct Examiners Handbook of the National Association of Insurance Commissioners (NAIC).

In addition to the general regulatory requirements for insurers, health maintenance organizations have other specific regulatory requirements to comply with. The additional market conduct requirements are found in U.C.A. Chapter 31A-8, Health Maintenance Organizations and Limited Health Plans, and in U.A.C. Rule R590-76, Health Maintenance Organizations.

EHC's operations were reviewed with regard to these additional specific regulatory requirements, including a review of provider relations materials, provider contract language, provider credentialing, provider malpractice insurance requirements, provider quality control procedures and provider complaint procedures.

Files were randomly selected except as otherwise indicated. Upon review of each file, any concerns or discrepancies were delivered to the Companies for their response. Some unacceptable or non-complying practices may not have been discovered in the course of this examination.

PERIOD COVERED BY THE EXAMINATION

A representative of the Utah Insurance Department conducted the last market conduct examination of the Companies as of December 31, 1997. The current examination covers the intervening period from January 1, 1998, through December 31, 1999. Significant transactions and/or events occurring after January 1, 2000, and noted during the course of the examination were reviewed.

COMPANY PROFILE

History

EMIA is a member of an insurance holding company system. The system consists of EMIA and its wholly owned subsidiaries: Educators Insurance Company, Educators Health Care, EIC Marketing Corporation and RX Direct, Inc. EMIA is a nonprofit mutual benefit association organized in accordance with the Utah Insurance Code. EMIA writes life and disability insurance on behalf of its membership which is comprised of individuals performing services for educational institutions, boards of education, the State of Utah, and other agencies or political subdivisions engaged in educational services. EMIA also assumes certain managed care type policies from EHC. Through administrative agreements, EMIA provides administrative services, for all its wholly owned subsidiaries and for certain self-insured groups.

EIC is a Utah domiciled for profit insurer licensed to write life, disability, annuities, and workers compensation insurance. The forepart of the Utah Insurance Department financial examination report of EIC as of December 31, 1999, contains a more detailed profile including history, affiliated companies, territory and plan of operations, and reinsurance arrangements.

EHC is a Utah domiciled non profit health maintenance organization governed by U.C.A. Chapter 31A-8 of the Utah Insurance Code. EHC wrote HMO coverage. In 1995, EHC discontinued writing new business and renewing existing contracts related to its medical lines of business, except for certain business that EHC ceded to EMIA and EIC. EHC also continued to write dental coverage for its capitated dental line of business. EHC's current plan of operations utilizes both (1) leased access to health care networks, consisting of physicians, hospitals and other health care providers, and (2) direct contracts with hospitals and physicians outside the network. EHC's provider contracts, with the exception of the capitated dental plan providers, were on a fee for service basis.

EIC Marketing Corporation is a brokerage firm marketing insurance and employee benefits. RX Direct is a pharmacy benefit manager for the Companies.

Company Growth

The premium, claims, and in force information on the following tables were taken from the Five -Year Historical Data section of the 1999 Annual Statements.

Educators Mutual Insurance Association

Year	Premiums & Related Expenses	Claims Paid	Life insurance In force
1999	$116,811,157	$119,956,179	* $ 706,422
1998	$117,710,029	$125,942,745	$1,016,663
1997	$103,146,146	$106,916,537	$1,053,799

*Premium increases resulted in decline in business.

Educators Insurance Company

Year	Premium Income	Claims Paid	Insurance in Force
1999	$15,005,429	$15,566,088	* $ 4,108
1998	$12,646,894	$11,943,249	$ 349,009
1997	$ 6,208,995	$ 5,410,027	$ 335,032

* Premium increase resulted in decline in business

Educators Health Care

Year	Premiums and related Expenses	Claims Paid	Enrollment
1999	$981,418	$2,313,291	*15,845
1998	$395,259	$ 313,211	1,301
1997	$460, 368	$ 298,075	1,625

*The increase in enrollment was due to EHC offering new dental Preferred Provider Organization (PPO) and Dental Maintenance Organization plans.

PREVIOUS EXAMINATION FINDINGS

The prior Market Conduct Examination Report and the Companies' responses to this report were reviewed. Eight items noted in the prior examination still remain applicable. These are:

1. Complaints were not responded to within 30 days. **(Complaints)**
2. Producers, which had not been appointed at the time of doing business, had been paid commissions. **(Producer Relationships)**
3. The Companies used forms that had not been previously filed with the Utah Insurance Department. **(Underwriting/Rating)**
4. The investigation of some claims was not completed within 30 days after receipt of information. **(Claims)**
5. There was insufficient documentation in files to show why the claim took over 30 days to process. **(Claims)**
6. The language of EHC's network lease agreement Attachment C with a major provider is not in accordance with the requirements of U.C.A. § 31A-8-407(1). **(Network Adequacy)**
7. EHC failed to develop a quality assurance plan, have the plan reviewed and certified, and show written evidence of continuing internal peer reviews of medical care given, as required by U.A.C. Rule R590-76, Health Maintenance Organizations (HMO). **(Quality Assessment)**
8. EHC also failed to prepare certified annual reports of the effectiveness of EHC's internal quality control, as required by U.C.A. Chapter 31A-8, Health Maintenance Organizations and Limited Health Plans. **(Quality Assessment)**

CURRENT EXAMINATION FINDINGS

Company operations/management

Internal Audits

EMIA's board of directors established an audit committee to review the operations of the Companies. This audit committee guided the functions of the Internal Audit department. The scope of the audit activities was planned in advance with senior management and the audit committee. Minutes of the audit committee were reviewed. It was noted that the internal auditor reports the results of all audits performed,
to the audit committee,

Antifraud Plans

EMIA had an antifraud plan in place to identify and investigate possible fraudulent claims for all Companies.

Certificates of Authority

The Certificates of Authority were reviewed. With regard to the lines of insurance authorized, the Companies were operating in conformance with their Certificates of Authority as issued by the Utah Insurance Department.

Complaint Handling

EMIA had written grievance procedures in place that applied to all companies. The insured could request a review of a claim or enrollment that had been denied, in whole or in part, by writing to the claims review committee. This committee was comprised of at least three employees who did not participate in the initial decision. If the insured did not agree with the findings of this committee, he or she could request a review by the executive committee. If dissatisfied with the decision of the executive committee, the insured could request a review by the board of directors. If still dissatisfied, the insured could make a written request for arbitration. The insured must exhaust all administrative remedies before initiating any action in small claims court. Arbitration is final if the amount in question is greater than the jurisdiction of the small claims court.

The complaint procedure specified that a complainant had 60 days, after an adverse decision, to file a complaint. However, the procedure did not specify the number of days for EHC to respond to the complaints. U.A.C. § R590-76-8.C has a thirty-day maximum response time for answering in writing a grievance received from an HMO enrollee.

Since the fall of 1997, the Companies have maintained a separate register for those grievances filed directly with the Companies and those filed with the Utah Insurance Department. The Companies registered a total of 1,148 complaints during the examination period. There were 25 justified complaints filed with the Utah Insurance Department during the examination period.

Complaint Handling Procedures

The examination reviewed and compared the Utah Insurance Department's complaint log against the Companies' logs to verify the accuracy of the Companies' tracking system. The examination also measured the Companies' response time to determine compliance with appropriate regulation. The reasons for and dispositions of the complaints were also reviewed.

The examination could not determine whether the complaints were related to EMIA, EHC or to EIC, due to the interchange of the various letterheads. Only EHC is required by statute to have a grievance policy.

The decision, on 67 percent of those complaints sent to review, was upheld.

In 1999, 30 complaints were sent to the board of directors for review. Five were subsequently approved.

During the course of the examination, the Companies implemented a "Service Committee" which meets weekly to discuss any service issues and how to resolve them.

Complaint File Review

Forty direct complaint files were reviewed. In 65% (26/40) of these files, an answer was not sent by the Companies until after 30 days. Failure to answer a grievance in writing within 30 days of submittal did not comply with U.A.C. § R590-76-8.C.

Two cases were improperly denied. Denial of a claim for a reason which is not clearly described in the policy did not comply with U.A.C. § R590-192-8(1).

Marketing and Sales

The Companies did not actively market their products. The Companies did only a limited amount of advertising. They did not advertise through radio, television, newspapers, or magazines. Mediums used for advertising included direct mail, point of sale brochures and flyers, phonebook listings and small promotional items, such as tote bags, pens and pencils, rulers, and calculators. The Companies would get a "Request for Proposal" directly from a client or through an agent. This proposal would have the criteria for coverage that the client wished, including demographics, claims history, etc. At that time the Companies would send a proposal package with information about the various products, list of benefits, etc.

EMIA donated money to the "Golden Apple" award, which awards the teacher of the year. EMIA's name was mentioned as a sponsor of this award.

Marketing materials used by the Companies were reviewed, including employer proposal packets. No discrepancies were noted.

Producer Licensing

The Companies used both in-house agents and outside independent agents to market their products. Currently all business of the Companies is produced through EIC Marketing Corporation, who receives all commissions and disburses them to designated agents.

Review of Files

A Utah Insurance Department list of current appointees dated March 21, 2000, was compared with a list of commissions paid, by company, for 1997 through 1999. There were no commissions listed as paid for EHC. The following discrepancies were not in compliance with U.C.A. § 31A-23-219(2)(a) which requires appointment prior to doing business for the insurer.

1. Two producers had been paid commissions by EMIA neither of whom had been appointed at the time of doing business.
2. Eight producers of EIC received commissions before being appointed.

Underwriting/Rating and Policy Holder Service

General

Large group medical, disability, dental and vision insurance plans were offered to group members and their dependents. The Companies did not offer small group insurance products. The Companies allowed one month from date of employment for the applicants to enroll for benefits without being required to provide proof of insurability

One year and five year term life products were sold to individuals within groups upon request. These products were not actively marketed. EHC underwrote PPOs, and dental PPOs. Premiums and claims were received directly by EHC and were then ceded to EMIA and EIC.

Policy Forms and Endorsements

The Companies used two forms that had not been previously filed with the Utah Insurance Department. Failure to file a form did not comply with U.C.A. § 31A-21-201(1), and U.A.C. § R590-86-3.A.

The Companies' written procedural guidelines were reviewed pertaining to underwriting, as well as policy forms and required filings. The following discrepancy was noted.

> Wording of the Adoption Indemnity Benefit in two forms EM.PLS.CON.D and EM.SE.BKT.C did not comply with U.C.A. § 31A-22-610.1, which states that a child must be placed within "90 days of the child's birth", not 30 days as listed in the forms. U.C.A. § 31A-22-610.1 also states that each policy covering the adoption will pay its pro rata share. These forms state that the benefit will be coordinated. The EM.PLS.CON.D form was re-

filed with correct wording subsequent to the examination.

The calculation of the six month look back for a Pre-existing Condition (PEC), in the Claims Processing Manual, referred to the effective date of coverage rather than the enrollment date as listed in the federal Health Insurance Portability and Accountability Act (HIPAA) § 701(a)(1)(A).

The creditable coverage letter sent to new insureds was vague as to what the company accepts as evidence of creditable coverage. It was not in compliance with HIPPA regulation 146.115.c. This regulation states that the individual may present, other than a letter from prior carrier, other credible evidence of coverage in order to establish the period of creditable coverage.

Underwriting /Policyholder Service File Review

Twenty-four certificate holder files were selected and requested for review. One enrollees' application had no signature or date.

One file had a back dated enrollment, which led to a claim of $65,492 being paid in error. The employee terminated August 31, 1999 and had a claim the following month and subsequently expired. The spouse sent in the COBRA application, which was approved and accepted on November 15, 1999. The filing period for filing a COBRA application is 60 days following termination.

Five group policies were chosen for review for completeness The Companies, on a monthly basis, reconciled their data with that of the group.

Claims

General

EMIA processed claims for its own members, as well as for EIC and EHC members. Death claims, and short-term and long-term disability claims were handled separately from other accident and health claims, which include HMO and indemnity plans, managed care and traditional dental plans, and vision plans. EMIA processed short-term and long-term disability claims, and then payment of the claims was done by an outside payroll firm. All other claims were both processed and paid directly by EMIA. Claims processed by EMIA included both paper claims and electronically submitted claims. Claim tapes were run every Friday and Wednesday and given to Anacomp, who produced and imaged the explanation of benefits (EOB) and checks and then returned them to EMIA. The checks were post dated five days after the run. EMIA then matched the EOBs with the appropriate checks and mailed them. EOBs were imaged only if they had an explanation as to why claims were denied or pended.

Claims Paid in Dollars

The following chart reflects the dollar amounts of life, accident and health (A&H), and HMO

claims paid during the examination period. The figures shown were taken from the Annual Statements (Five -Year Historical Data section) of the Companies.

Year – Line of Business	EMIA	EIC	EHC
1999 – Life	$ 1,466,204	$ 131,557	n/a
A & H	$118,489,975	$15,434,531	n/a
HMO	n/a	n/a	$ 2,313,291
1998 – Life	$ 1,534,618	$ 399,504	n/a
A & H	$ 123,508,127	$11,543,745	n/a
HMO	n/a	n/a	$ 313,211

Claims Processing

The Companies had written procedures/guidelines detailing how claims were to be processed. There were some instances where procedures were not always complied with. Additional procedures were implemented during the examination period. Some of these additional procedures were tested and verified as functioning after the implementation date.

In 1998 and the first part of 1999, EMIA was closing claims after 60 days for reasons other than denial or payment. This did not comply with U.A.C. § R590-89-12.B that requires notification to the insured until the claim is either denied or paid.

Claim File Review

A sample of 81 health claims for the years 1998 and 1999 were selected for review. This review included:

- Thirty-five paid and denied claims, eleven of which were electronically submitted.
- Thirteen claims paid in 2000, incurred in 1999.
- Seven claims, with paid amounts greater than $100,000.
- Nineteen pended claims all of which were subsequently paid or denied in 2000.
- Seven claims, with amounts paid greater than $100,000 and a paid date after the implementation of the Companies' updated procedures and controls. This was to determine if the new procedures were being followed.
- Seventeen death claims.

The following discrepancies were noted:

1. Fifteen claims did not comply with U.A.C. § R590-192-(7)(3): investigation of claims shall be completed within 30 days after receipt of completed notice unless the claim file documents why and documents notice of why to the claimant.
2. There was insufficient documentation in four files to show why the claim took over 30 days

to process. These were not in compliance with U.A.C. § R590-192-4: adequate documentation shall be contained in each claim file in order to reconstruct the adjustment and settlement of each claim.

3. One claim was overpaid by $788,301. The first provider billing of $352,804 was paid in May 1999. When an additional billing was received, the claim was pended by an internal auditor for verification of benefits. In August 1999, the pended code was overridden and the additional amount was paid. After complete review of the claim, the Company determined that no benefits were payable. A refund was originally requested November 29, 1999. After discovery of this overpayment, the Companies implemented a procedure where three people need to review and sign off before any claim over $100,000 can be paid. All the claims reviewed that were paid after implementing the change did follow this policy, even those received electronically.
4. Seven claims were paid as primary insurer, but should have been paid as secondary insurer.
5. One claim was paid in error, due to the backdating of the enrollment application.
6. EIC did not pay the full death benefit for one claim. The benefit was reduced by the amount of an overpayment on a disability claim. However, neither file documented why the settlement was done this way. This did not comply with U.A.C. § R590-192(4)(2): which requires adequate documentation in file allowing for reconstruction of claim.

Specific requirements for Health Maintenance Organizations

In addition to the general regulatory requirements for insurers, health maintenance organizations have other specific regulatory requirements to comply with. The additional market conduct requirements are found in U.C.A. Chapter 31A-8, Health Maintenance Organizations and Limited Health Plans, and in U.A.C. Rule R590-76, Health Maintenance Organizations. The following items apply only to Educators Health Care.

Network Adequacy

EHC utilized both leased access to a health care network and direct contracts with providers outside of the network. EHC's primary provider network was leased through IHC Health Care Plans, Inc. EHC paid an access fee, based on a per capita charge, to lease the IHC network.

Language in the Educators Health Plus Provider Directory did not comply with U.A.C. § R590-130-12(A) which requires the actual name of the insurer in all advertisements. It stated "Educators Care Plus is a health maintenance organization." Educators Health Care is the Health Maintenance Organization not Educator Care Plus.

The language of EHC's "Network Access Agreement" and Facility Services Agreement was not in accordance with the requirements of U.C.A. § 31A-8-407(1) which states the member cannot be balanced billed. The prior financial examination and market conduct examination (as well as the market conduct examination of the provider) recommended that this language be changed. This agreement states: "The requirement that a Facility not bill a Member for Covered Services shall not apply in the event of non-payment by Company or a Purchaser under contract with Company including but not limited to a non-payment due to insolvency or for breach of this

Agreement by Company or a Purchaser under contract with Company."

Utilization and Review

EHC formerly used Intracorp for its utilization review process, but during the examination period this contract was terminated. EHC now uses Critique for its pre-admission certification, concurrent stay reviews, discharge planning and hospital bill review/audit. This process and the reports of this process were reviewed with no discrepancies noted.

Quality Assessment and Improvement

EHC failed to develop a quality assurance plan, have the plan reviewed and certified, and show written evidence of continuing internal peer reviews of medical care given, as required by U.A.C. § R590-76-10.

EHC also failed to prepare certified annual reports of the effectiveness of EHC's internal quality control. Failure to prepare the annual reports did not comply with U.C.A. § 31A-8-404.

Provider Credentialing

EHC leased the provider networks of Chiropractic Health Program and Intermountain Health Care. These two entities did the credentialing for the providers in their network. EHC did the credentialing for those providers they contracted with directly, which were those in SelectCare. Initial credentialing involved verifying education and medical history, including degrees, certification, licenses, malpractice insurance history and experience.

Provider Files

Provider directories were supplied by EHC from which 18 provider contract files, chosen for a variety of provider types, were requested for review. Following are the results of this review:

- In two files, although the provider's name was listed in the provider directory, the provider contract was not available for review by the examiner. Failure to maintain all provider contracts on file and available for review did not comply with U.A.C. § R590-76-9.
- There were nine files with incomplete contracts. Failure to have a written contract in effect was not in compliance with U.C.A. §§ 31A-8-407(1) and (2). These contracts were verified as corrected by the examination.

SUMMARIZATION

Comments included in this report which are considered to be significant and requiring special attention are summarized below:

Summary

1. Eight items noted in the prior market conduct examination still remain applicable. These are:

   - Complaints were not responded to within 30 days. Twenty-six of the complaint files reviewed were not responded to within thirty days. Failure to answer a grievance in writing within thirty days of submittal did not comply with U.A.C. § R590-76-8.C. The prior examination listed four complaints that did not meet this criterion. **(Complaints)**
   - Ten producers had been paid commissions, during the examination period, who had not been appointed at the time of doing business. Two of these were paid by EMIA and eight by EIC. This was not in compliance with U.C.A. § 31A-23-219. The Prior examination listed nine agents that were not appointed at the time of doing business. **(Producer Relationships)**
   - The Companies used two forms that had not been previously filed with the Utah Insurance Department. Using a form without filing it with the commissioner is not in compliance with U.C.A. § 31A-21-201(1) and U.A.C. § R590-86-3. **(Underwriting/Rating)**
   - Fifteen claims did not comply with U.A.C. § R590-192-(7)(3): investigation of claims shall be completed within 30 days after receipt of completed notice unless the claim documents why and documents notice of why to the claimant. **(Claims)**
   - There was insufficient documentation in four files to show why the claim took over 30 days to process. These were not in compliance with U.A.C. § R590-192-4. **(Claims)**
   - The language of the Companies' network lease agreement Attachment C with a major provider was not in accordance with the requirements of U.C.A. § 31A-8-407(1). **(Network Adequacy)**
   - EHC failed to develop a quality assurance plan, have the plan reviewed and certified, and show written evidence of continuing internal peer reviews of medical care given, as required by U.A.C. § R590-76-10. **(Quality Assessment)**
   - EHC failed to prepare certified annual reports of the effectiveness of EHC's internal quality control. Failure to prepare the annual reports did not comply with U.C.A. § 31A-8-404. **(Quality Assessment)**

2. Two claims were improperly denied and therefore did not comply with U.A.C. § R590-192-8(1). **(Complaints)**

3. Wording of the Adoption Indemnity Benefit in two forms, EM.PLS.CON.D and EM.SE.BKT.C, was not in compliance with U.C.A. § 31A-22-610.1, which states that a child must be placed within "90 days of the child's birth", not 30 as listed in the forms. U.C.A. § 31A-22-610.1 also requires each policy covering the adoption to pay its pro rata share. These forms state that the benefit will be coordinated. The EM.PLS.CON.D form was re-filed with correct wording subsequent to the examination. **(Underwriting/Rating)**

Examiner's Comments in Reference to Policyholder Treatment

Generally, members appear to have been treated correctly and fairly by the Companies. However, recorded complaints were not always responded to in a timely manner.

Acknowledgement

The cooperation and assistance rendered by the officers and employees of the Companies during this examination is hereby acknowledged and appreciated.

Sincerely

Brian W. Hansen, FLMI, CFE, AIE
Market Conduct Examiner
Examiner-in-Charge
Utah Insurance Department

4. The calculation of the six month look back for Pre-existing Condition (PEC) in the Claims Processing Manual referred to the effective date of coverage, rather than the enrollment date which is the standard as stated in HIPAA § 701(a)(1)(A). **(Underwriting/Rating)**

5. The creditable coverage letter sent to new insureds was vague as to what the company accepted as evidence of creditable coverage. This letter was not in compliance with HIPAA regulation 146.115.c. This regulation states that the individual may present, other than a letter from prior carrier, other credible evidence of coverage in order to establish the period of creditable coverage. **(Underwriting/Rating).**

6. In 1998 and the first part of 1999, EMIA was closing claims after 60 days for reasons other than denial or payment. This did not comply with U.A.C. § R590-89-12.B that requires notification to the insured until claim is either denied or paid. **(Claims)**

7. One claim was overpaid by $788,301. The first provider billing of $352,804 was paid in May 1999. When an additional billing was received, the claim was pended by audit for verification of benefits. In August 1999, the pended code was overridden by claims and the additional amount was paid. The Company determined that no benefits were payable. A refund was originally requested November 29, 1999. **(Claims)**

8. Eight additional claims totaling $358,086 were overpaid. Seven of these were paid as primary insurer rather than secondary. One claim was paid in error, due to the backdating of the enrollment application. These funds have been recovered. **(Claims)**

9. EIC did not pay the full death benefit for one claim. The benefit was reduced by the amount of an overpayment on a disability claim. However, neither file documented why the settlement was done this way. This did not comply with U.A.C. § R590-192(4)(2): which requires adequate documentation in file allowing for reconstruction of claim.**(Claims)**

10. Language in the Educators Health Plus Provider Directory did not comply with U.A.C. § R590-130-12(A) which requires the actual name of the insurer in all advertisements. It stated "Educators Care Plus is a health maintenance organization." Educators Health Care is the Health Maintenance Organization not Educator Care Plus. **(Network Adequacy)**

11. There were two cases where the providers' names were listed in the provider directory of directly contracted providers, but the provider contracts were not available for review by the examiner. Failure to maintain all provider contracts on file and available for review did not comply with U.A.C. § R590-76-9. **(Provider Credentialing)**

12. There were nine files with incomplete contracts. Failure to have a written contract in effect did not comply with U.C.A. §§ 31A-8-407(1) and (2). EHC provided the examination with amended contracts and the examination verified that these contracts had been corrected. **(Provider Credentialing)**